Request for Extension of Benefits

Member Instructions: Fill out the Member Information section, sign the two releases at the bottom of this form, then give the form to your provider for them to complete and send to Wellfleet.

What type of Extension of Benefits are you requesting?

☐ Continued IP Stay after Term Date ☐ Maternity ☐ Total Disability

Please complete all fields. If you have questions, contact Wellfleet Customer Service:
Phone: 877.657.5030 | **Email**: customerservice@wellfleetinsurance.com

Mail, fax, or email this completed form and attachments to: Wellfleet | PO Box 15369 | Springfield, MA 01115-5369 **Fax**: 413.733.4612 | **Email**: customerservice@wellfleetinsurance.com

Member Information

Member Name:_____
Wellfleet ID Number:_____
Mailing Address:_____
Phone Number:_____

Attending Provider Information

Provider Name:_____
Provider TIN:_____
Mailing Address:_____
Phone Number:_____

Facility Information (Maternity-Provide Planned Birthing Center or Hospital Information)

Facility Name:_____
Facility TIN:_____
Contact at Facility:_____
Mailing Address:_____
Phone Number:_____

Disability or Continued IP Stay Information (to be completed by attending provider)

Member's primary disabling diagnosis and/or injury:_____
Disabling diagnosis and/or injury start date: _____
Member's history of diagnosis/injury:_____
Member's current clinical status:_____
Member's treatment plan:_____
Member's prognosis:_____

Maternity

Estimated Due Date:_____
Current Medication(s):_____
Single, Twins or Multiple Birth Expected: _____

Please also include/attach all medical records supporting your request for extension of benefits due to total disability as "total disability" is defined in your student health plan policy documents.

During your Extension of Benefits additional medical conditions associated with your approved extension diagnosis may occur. Please contact Wellfleet directly to provide additional information related to your approved extension diagnosis.

Member Signature and Release

I (the undersigned) am authorizing Wellfleet Insurance Company/Wellfleet New York Insurance Company (Wellfleet) to collect information about the member's health in connection with a request for an extension of benefits due to disability. I understand that I may refuse to sign this authorization; however, if I do not sign this authorization, my failure to do so may result in denial or delay of benefits. I understand I may revoke this authorization by submitting a written revocation to Wellfleet at: Privacy and Security Officer, c/o Wellfleet Group, LLC, P.O. Box 15369, Springfield, MA 01115. I understand my right to revoke this authorization is limited to the extent that Wellfleet has taken action in reliance of the authorization. This authorization is valid for the period under which a claim may be submitted.

I represent to the best of my knowledge and beliefs, the statements and answers made by me on this form are complete, truthful and correct. I understand that my request for extension of benefits is subject to approval by Wellfleet based upon the applicable health plan and the documentation submitted to Wellfleet in support of this request. I attest that I am not employed in any capacity for pay or profit contingent upon this request. If this request is approved, I will notify Wellfleet should the disability condition resolve prior to the end of the coverage period.

_____

Member Signature Date

(or Authorized Representative- parent, guardian, other legal representative)

Healthcare Provider Authorization to Release Information

You are authorized to provide Wellfleet or its affiliate, including claims affiliated administrators and entities performing utilization review services on behalf of Wellfleet, information concerning healthcare treatment, services or advice (including information concerning HIV, substance abuse and mental illness) relating to the individual who is the subject of this release. The information you provide will be used to evaluate a request for extension of benefits.

_____

Member Signature Date

(or Authorized Representative- parent, guardian, other legal representative)